TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Trophy Club Medical Center

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-17-0707-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 14, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: $9,591.99

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 18 – 20, 2015	Outpatient Hospital Services	$9,591.99	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out requirements of prior authorization.
3. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 18 – Exact duplicate claim/service
   - 252 – An attachment/other documentation is required to adjudicate this claim/service

- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- P12 – Workers' Compensation jurisdictional fee schedule adjustment
- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal

The requestor is seeking reimbursement of $9,591.99 for outpatient hospital services rendered on November 18 - 20, 2015. Outpatient hospital services are subject to the requirements of 28 Texas Administrative Code 134.403 (d) which states in pertinent part,

> For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided...

The applicable Medicare payment policy is found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

In order to calculate the correct Division fee guideline, stakeholders should be familiar with the main components in the calculation of the Medicare payment for OPPS services, which are:

- **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf,
    - *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.*
- **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum D1.
- **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.
- **Composite APC** - Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service that is defined, for purposes of the APC, as a service typically reported with multiple HCPCS codes. When HCPCS codes that meet the criteria for payment of the composite APC are billed on

the same date of service, CMS makes a single payment for all of the codes as a whole, rather than paying individually for each code.

Issues

1. Is the carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule that applies to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied the disputed services C1713 and C1762, with claim adjustment code "252 – An attachment/other documentation is required to adjudicate this claim/service."

   Review of the submitted "0perative Report" finds no mention of the narrative description of code C1762 or "Amniotic Fluid" as listed on the "Itemized Bill." The carrier's denial supported as no documentation found to support the services rendered as billed. No payment recommended.

   28 Texas Administrative Code §134.403 (g) states in pertinent part,

   > Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.

   Review of the "Itemized Statement" for items listed as C1713 found the following descriptions; Suture Fiberlink 26 in, Tape Fibertape 2mm x 36m, Tape Tigertape 2mm x 7in and Anchor Sut 4.75 x 24.5mm.

   The "Arthrex" invoices listed the above items are dated July 8, 2016, September 20, 2016, and October 6, 2016. The dates of service in dispute are for November 18 – 20, 2015. The invoice dates are after the services in dispute were rendered. The carrier's denial for lack of documentation is supported. No payment recommended.

   The remaining services in dispute, "other outpatient services" and 29827 will be reviewed per the applicable fee guidelines discussed below.

2. 28 Texas Administrative Code §134.403 (f) states in pertinent part,

   > The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   >
   > (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   >
   > (A) 200 percent; unless
   >
   > (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

Review of the submitted medical claim finds separate reimbursement for implantables was requested therefore, the services in dispute are reimbursed based on the following:

Submitted code	Status Indicator	APC	Payment Rate	Unadjusted labor amount = APC payment x 60%	Geographically adjusted labor amount = unadjusted labor amount x annual wage index 0.9512	Non labor portion = APC payment rate x 40%	Medicare facility specific reimbursement (geographically adjusted labor) amount + non labor portion)	Maximum Allowable Reimbursement
29827	T	0042	$4,345.55	$4,345.55 x 60% = $2,607.33	$2,607.33 x 0.9512 = $2,480.09	$4,345.55 x 40% = $1,738.22	$2,480.09 + $1,738.22 = $4,218.31	$4,218.31 x 130% = $5,483.80
							Total	$5,483.80

The services listed on the DWC060 as "other outpatient services" are classified as follows:

- Procedure code C1713 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code C1762 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 36415, date of service November 18, 2015, has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 80053, date of service November 18, 2015, has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 81001, date of service November 18, 2015, has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 87389, date of service November 18, 2015, has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 85025, date of service November 18, 2015, has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 85610, date of service November 18, 2015, has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 85730, date of service November 18, 2015, has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 81015, date of service November 18, 2015, has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 71020, date of service November 18, 2015, has status indicator Q3 denoting conditionally packaged codes paid through a composite APC if OPPS criteria met; however, review of the submitted information finds that the criteria for composite payment have not been met.

  The Medicare facility specific reimbursement amount for this line is $57.63. This amount multiplied by 130% yields a MAR of $74.92.
- Procedure code J0690 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J1170 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J1885 has status indicator N denoting packaged items and services with no separate APC payment.

- Procedure code J2175 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J2250 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J2405 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J2250 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J3010 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J7030 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 93005 has status indicator Q1 denoting STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date.

3. The total allowable reimbursement for the services in dispute is $5,558.72. This amount less the amount previously paid by the insurance carrier of $5,558.73 leaves an amount due to the requestor of $0.00. No additional reimbursement recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		December 6, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.